



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STONEGATE SURGERY CENTER
2501 WEST WILLIAM CANNON DRIVE SUITE 3
AUSTIN TX 78745-5256

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative

Box Number 01

MFDR Tracking Number

M4-13-1127-01

MFDR Date Received

JANUARY 7, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we correctly billed 29875 with the -59 modifier as it was a separate procedure from the other procedure performed."

Amount in Dispute: \$5,040.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our decision to deny CPT 29875-59, as an integral part of CPT 29881 is supported by Medicare Correct Coding Guidelines and remains the same."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|-------------------|--|-------------------|------------|
| February 15, 2012 | ASC Services for CPT Code 29875-SG-59-LT | \$5,040.00 | \$1,378.72 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, effective May 31, 2012, sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- U008-This separate independent procedure is considered an integral part of the total services performed and does not warrant a separate charge.
- B15-Payment adjusted because this procedure/service is not paid separately.

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states “ For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.”

The respondent denied reimbursement for CPT code 29875-SG-59-LT based upon EOB denial reason codes “u008 AND B15.”

CPT code 29875 is defined as “Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure).”

On the disputed date of service the requestor billed CPT codes 29881-SG-LT and 29875-SG-59-LT.

CPT code 29881 is defined as “Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed).”

Per NCCI edits CPT code 29875 is a component of CPT code 29881; however, a modifier is allowed when appropriate. The requestor utilized modifier “59” to differentiate it as a separate service.

Modifier 59’s descriptor is “**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-Evaluation and Management (E/M) services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together but are appropriate under the circumstances.

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used.”

The February 15, 2012 Operative report indicates that the claimant underwent “Examination under anesthesia; Diagnostic left knee arthroscopy; Partial medial meniscectomy, complex; Anteromedial/anterolateral compartment synovectomy; Medial femoral condyle chondroplasty, limited; Intra-articular injection; and Simple closure.”

The Division finds that the requestor supported the use of modifier 59 because CPT code 29875 was performed in both the lateral and medial compartment. CPT code 29881 was performed in the medial compartment; therefore the synovectomy performed in the medial compartment is global to CPT code 29881. However, the synovectomy performed in the lateral compartment is not; therefore, reimbursement is recommended.

28 Texas Administrative Code §134.402(f)(1)(A) states “The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.”

According to Addendum AA, CPT code 29875 is a non-device intensive procedure.

The City Wage Index for Austin, Texas in Travis County is 0.9535.

The Medicare fully implemented ASC reimbursement for code 29875 CY 2012 is \$1,201.33.

To determine the geographically adjusted Medicare ASC reimbursement for code 29875:

The Medicare fully implemented ASC reimbursement rate of \$1,201.33 is divided by 2 = \$600.66

This number multiplied by the City Wage Index is \$600.66 X 0.9535 = \$572.72.

Add these two together \$600.66 + \$572.72 = \$1,173.38.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%: \$1,173.38 X 235% = \$2,757.44.

CPT code 29875 is subject to multiple procedure discounting: \$2,757.44 X 50% = \$1,378.72.

The MAR is \$1,378.72. The respondent paid \$0.00. The requestor is due the difference between the MAR and amount paid = \$1,378.72.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,378.72.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$1,378.72 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

8/22/2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d). **Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**